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DOCUMENT SECTION

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SURGEON'S CIRCULAR LETTER



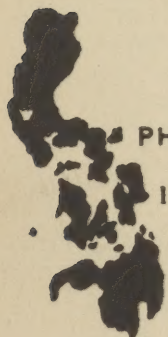
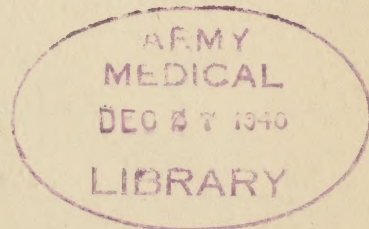
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This Issue Contains the 1948
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Authors and Articles

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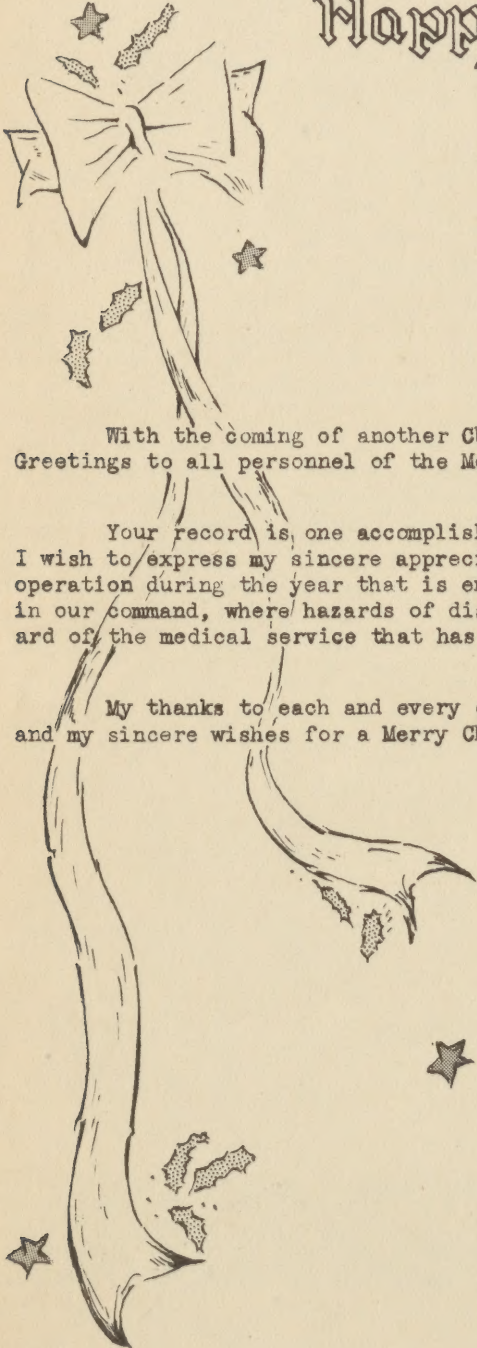
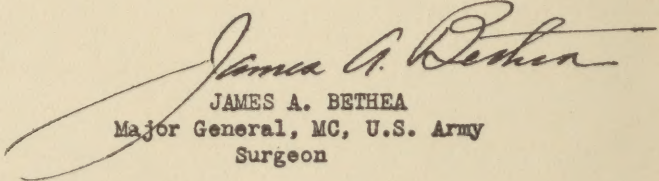
Merry Christmas Happy New Year

25 December 1948

With the coming of another Christmas, I wish to extend the Season's Greetings to all personnel of the Medical Department in the Far East Command.

Your record is one accomplished in a highly commendatory manner and I wish to express my sincere appreciation for your splendid effort and co-operation during the year that is ending. The good health of the troops in our command, where hazards of diseases are great, reflects the high standard of the medical service that has been contributed.

My thanks to each and every one of you for your loyal cooperation and my sincere wishes for a Merry Christmas and a Happy New Year.



JAMES A. BETHEA
Major General, MC, U.S. Army
Surgeon

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER
NUMBER.12

APO 500
1 December 1948

PART I

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I. Organization of the Medical Section

Departure. Lt. Colonel Rosalie D. Colhoun, ANC, Chief Nurse, Far East Command, completed her tour of duty and has left for her new assignment in the zone of interior.

Arrivals. Lt. Colonel Arthur P. Long, MC, arrived from the zone of interior to assume the duties of Preventive Medicine Consultant, Medical Section, General Headquarters, Far East Command.

Lt. Colonel Everett W. Partin, MSC, formerly Executive Officer of the St. Louis Medical Depot arrived in the Medical Section, General Headquarters, Far East Command, to assume the duties of Director, Supply and Fiscal Division.

Major Mildred I. Clark, ANC, formerly Chief Nurse, Headquarters, XXIV Corps, arrived in the Medical Section, General Headquarters, Far East Command, to assume the duties of Chief Nurse, Far East Command.

II. Thoughts on a Career in Medicine

Medical Corps officers, have you decided on your future medical career? Two extracts published by prominent civilians in the field of medicine are presented for your information and thought.

The following article "What Doctors Make" is quoted from the 4 October 1948 issue of "Newsweek":

"The medical specialist's financial edge on the general practitioner is not what it used to be. Full specialists in 1943 netted on the average about 59 per cent more than GP's. By 1947 this had dropped to 51 per cent, according to figures published this week in Medical Economics.

"In the 1947 survey edited by that journal, the average GP net income is listed as \$9,541; of partial specialists, \$11,515; and of full specialists, \$14,442.

"In selected specialties, the radiologist tops the list with an average net of

\$20,319. The gynecologist-obstetrician is second with \$17,320; the eye-ear-nose man third with \$16,067. Surgeons netted \$16,011, psychiatrists, \$14,774; urologists, \$13,848, dermatologists, \$13,458, and pediatricians, \$11,902.

"Lowest average incomes are reported by doctors in the New England and Middle Eastern states; highest in the Far West; next highest in the Southwest. Striking contrasts were noted in income variations by states. Connecticut doctors, for instance, earn more on the average than those in Massachusetts. Florida is above the average of Southern states.

"Highest average incomes in 1947 were reported by doctors in cities of 500,000 - 999,999. This marked a shift from 1943, when the top average was found in localities of 100,000 - 499,999. Among doctors in the country's seven largest cities, top average is noted in Los Angeles; lowest in New York. The fifteenth year of practice is usually the peak earning year."

The following introduction by Dr. Allen O. Whipple, former President, American Board of Surgery, to an article entitled "Give Young Doctors a Break", appears in the October 1948 issue of "Woman's Home Companion":

"There is no question that well-trained physicians and surgeons, after completing their training as medical students, interns and residents, and after being certified by the rigid examination of the National Qualifying Boards - a training of five or more years after graduation from medical school, as compared to one year internship - are far better qualified and more competent than many of the older practitioners in the smaller cities of this country. There is no doubt that these younger qualified doctors are prevented from demonstrating their ability in a good number of communities by the failure of the local physicians to give these younger men opportunity to practice in the hospital or hospitals of the community."

From the above statement, it appears that many civilian communities are being denied a superior type of medical and surgical service which would result from the practice of well-trained and alert young physicians and surgeons; yet the Army, unlike these communities, is offering young medical men opportunity for an honorable, profitable and professionally satisfying career.

In order to present the position of the Army regarding its medical program for young doctors, a few comparisons might be employed.

With the exception of the few fortunate young doctors who have decided on the general practice of medicine, or chosen a specialty career and have ready-made situations awaiting them, the majority of young doctors are confronted with the problem of where to establish a practice; or how and where to obtain the best additional specialty education and training which may be needed to further their careers.

In considering these problems the first of importance is where to practice. In a great many communities older doctors do not want the aggressive competition of the younger physicians. Consider the Army as a community. The young physician has a ready-made practice which welcomes his training and enthusiasm, and offers him an income which, with all emoluments including retirement benefits, compares most favorably with the average income of civilian general practitioners and specialists.

Competition? - definitely, but not of a financial nature which so often causes a man to lose faith with himself and his ideals, but that competition which centers around thoughts of rendering greater service.

Where and how to obtain the best additional specialty education and training. It is a well-known fact that the number of good residencies available are completely out of proportion to the number of capable men who apply for them and when a young man is fortunate enough to be selected for one of these few, he again has a financial problem to consider - at that time and for years to come - until he has become established in his specialty. Not being well-known or recommended, for many years his talents must await petition.

The Army is offering a solution to this problem. Its Residency Program is comparable to any offered in civilian hospitals without the specter of financial worry. No - the Army is not offering great monetary rewards for professional services, it merely alleviates a financial strain and allows the young doctor to concentrate on his profession.

The Army is not a Utopia for the doctor. However, physicians and surgeons who exhibit special aptitude and capacities will be encouraged to complete their specialty training. Those

men may expect to remain in that specialty field. Just as in teaching hospitals in civilian medicine, the specialty field is competitive. Take, for example, a university hospital which accepts thirty men as senior residents. At the end of that year perhaps five of that group will remain as chief residents or house physicians or house surgeons. It is easily seen that each man's advancement, either in a civilian teaching hospital specialty training program or in the Army program, will largely depend on his own capacity for attainment of skills as well as on his initiative, determination and will to work.

The Army is offering excellent training, financial security, opportunity for additional knowledge and research. Not all doctors, by temperament, will make good Army doctors, but to you who are temperamentally suited and aware of its possibilities - the Army will give - for you to take - a better life for yourself and your fellow countrymen.

III. Civilian Patients

Information received by the Medical Section, GHQ, FEC, reveals that civilian personnel evacuated to the United States as patients are being informed that necessary treatment and hospitalization will be provided at Army hospitals in the United States. Such treatment and hospitalization are not authorized certain civilians under the provisions of AR 40-590 and Section II, WD Circular 266, 1946.

Belief by the civilian patients that they will, upon arrival in the zone of interior, be provided hospitalization in U.S. Army hospitals, has resulted in embarrassment to the Department of the Army, and hardship to the misinformed civilians. As no other adequate medical facilities are available in the Far East Command, U.S. civilians are provided medical care and hospitalization in U.S. Army medical facilities. The receipt of medical care and hospitalization in Army medical facilities in the Far East Command does not establish a criteria for similar medical service in the United States.

In view of the foregoing, it is considered that all Medical Department personnel should refrain from erroneously informing U.S. civilian patients that they will be provided further medical service in U.S. Army hospitals upon arrival in the zone of interior. Information provided should be limited to the statement that debarkation hospitals will determine the disposition of each patient.

IV. Army Medical Department Establishes Seven New ROTC Units

The Army Medical Department has established seven new Medical Corps ROTC units in medical colleges to bring the total number to 50. The units which will be in operation for the first time during the 1948-49 academic year are at the following institutions: Boston University School of Medicine, Columbia University Medical School, Harvard University School of Medicine, University of Kansas Medical School, Medical College State of South Carolina, Tulane University School of Medicine, and University of Washington School of Medicine.

In addition to the 50 Medical Corps units, the Department will have 18 Dental Corps ROTC units, 6 Veterinary Corps units and 4 Pharmacy Corps units.

Students in all Medical Department ROTC units may earn Reserve commissions as first lieutenants through four years of training with 90 hours of training a year.

The 4-year Medical Corps course is divided into two sections, basic and advanced. Students in the advanced course (juniors and seniors) are paid commutation of the Army garrison ration for a maximum of 570 days. The commutation for the 1947-48 academic years was fixed at 78 cents a day. Students are required to attend one summer camp of six weeks for which they are paid at the rate of \$75 a month.

World War II veterans may receive credit for part or all of the basic course, dependent upon length of war service.

V. Pillow for Allergic Patients

Air Foam mattresses have recently been automatically distributed to hospitals. In con-

nection with the use of this item, it might be desirable to also have an allergic free pillow. There are available air pillows, rubberized, ten by fifteen inches in size, at the larger Post Exchanges. This item, when used by hospitalized allergic patients, is a legitimate purchase from Hospital Funds.

VI. Household Remedies

The following pharmaceutical houses in the San Francisco area will recognize individual orders from dependents and civilians for pharmaceuticals and home remedies not routinely supplied by Army facilities. Special medicine may be obtained by sending a prescription in letter inclosing money order to cover the cost of the medicine desired and airmail postage.

Prescription Pharmacy, 2101 Van Ness Avenue, San Francisco, California
 Post-Scott Pharmacy, 2205 Post Street, San Francisco, California
 Sterling Pharmacy, 400 Kearny Street, Cer. Pine, San Francisco, California

VII. Processing Requisitions for Bed Lamps

It has been ascertained that all bed lamps now in stock are equipped with clamps for use on the round head rail of hospital beds under Stock No. 7-060-500, Lamp, Hospital Bed, Adjustable Clamp. At present there are no bed lamps in stock equipped with clamps for use on square tubing for the Far East Command.

Procurement of Stock No. 7-060-575, Lamp, Hospital Bed, Universal Clamp, has been initiated and oversea areas will be notified when stocks are available for issue. Until stocks are available requisitions specifying bed lamps with universal clamps or clamps to fill square head rail hospital beds should be canceled.

VIII. Sodium Monofluoracetate (Compound 1080)

Department of the Army Circular #267 and Air Force Letter 160-7, dated 30 August 48, places restrictions on the issue of sodium monofluoracetate (compound 1080) except when required for special problems of rat-and field-rodent control on military installations.

Sodium monofluoracetate (compound 1080) is a white deliquescent powder. It is readily soluble in cold water but practically insoluble in all organic solvents. This product has a mild acid taste and acetate odor. It is not irritating to and not absorbed by the intact skin. It is highly toxic to all mammals being particularly dangerous to dogs and cats. This characteristic is responsible for much of its secondary poisoning hazard since these pets are killed upon eating sick or dead rodents which have eaten 1080. The poison is very dangerous to man and caution must be exercised in handling and exposing it. There is no effective antidote for it and treatment of accidental poisoning is limited to immediate use of an emetic and sedatives.

The Circular states that when a requisition is submitted for 1080 for required operations, the requisition will show justification for the choice of this rodenticide and will be submitted through the unit or installation surgeon to the appropriate command for approval. Also, the requisition will be reviewed by a qualified entomologist at command headquarters prior to approval and forwarding to the appropriate depot for supply.

(ED NOTE: For further discussion of 1080, refer to Surgeon's Circular Letter #2, dated 1 February 1948.)

IX. Information for Nurses

In connection with the expanded program of the Army Nurse Corps, it has just been announced that extension courses are now available to Reserve Nurses. These cover topics in military orientation and hospital administration.

At the Medical Field Service School, Fort Sam Houston, Texas, two Army Nurses have been

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assigned to prepare subcourses to the extension series, which will especially appeal and assist nurses in their professional needs. These courses are available to nurses wishing to enroll.

Interested Reserve Nurses should address inquiries to the Director, Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas; also to the Unit Instructor, Organized Reserve Corps in their area.

Two other announcements of importance to members of the ANC Reserve and to civilian nurses who contemplate becoming members of the Reserve are as follows:

First, Those who accept extended active duty but have not had previous military experience will be given an allowance of \$250 to cover their initial purchase of uniforms. With their first pay voucher, a certified statement will be made that no previous allowance or uniform issue had been made.

Second, Credit hours for the completed extension courses at the Medical Field Service School will count toward promotion and retirement. The Reserve Nurse up through the grade of Major, whether on extended or inactive status, will have the privilege of these six complete extension courses. They are written especially for nurse officers but follow the subject matter of special courses offered Army Nurses at the Medical Field Service School.

Retirement Benefits

Reserve members who meet the standards of performance required for active duty of the Army Nurse Corps are now eligible for retirement benefits. Those nurses of the organized reserve at the age of 60, who have completed 20 years of satisfactory Federal Service will be eligible. Fifty points may accrue each year by the following: (1) extended active duty, (2) active duty training for short periods, (3) attendance at drills (Training Meetings), (4) by being a member of the Officers Reserve Corps. Thus civilian nurses not on extended active duty may accumulate points toward retirement.

The retirement pay is determined at the rate of 2½% of the pay of the highest grade held times the number of years of satisfactory service and by total points. An Army Nurse after 20 years of satisfactory service may discontinue active participation and still qualify for retirement when 60 years of age or she may desire to earn points until she is 60 years of age and retire up to 75% of her base and longevity pay.

X. MOS's and Titles Common to the Medical Department

2110	Adjutant or Adjutant General	3106	Ophthalmologist and	3171	Oral Surgeon, Dental
2120	Administrative Officer		Otorhinolaryngologist	3172	Exodontist
2200	Military Personnel Officer	3107	Cardiologist	3174	Periodontist
2201	Personnel Assignment Officer	3108	Obstetrician and	3175	Prosthodontist
2205	Director of Personnel		Gynecologist	3178	Dental Officer, Staff
2210	Classification & Assignment Officer	3111	Urologist	3180	Physical Therapist
		3112	Dermatologist	3182	Diagnostic & Therapeutic Radiologist
2252	Psychologist	3113	Allergist		
2431	Medical Registrar	3115	Anaesthesiologist	3184	Diagnostic Radiologist
2520	Training Officer	3116	Pediatrician	3200	Veterinary Officer, General
2616	Plans & Policies Officer	3125	Ophthalmologist	3201	Veterinary Officer, Large Animal
2700	Student Officer	3126	Otorhinolaryngologist	3202	Veterinary Officer, Small Animal
3000	Medical Officer, Staff	3128	Neurologist	3203	Veterinary Officer, Staff
3005	Medical Officer, Preventive Medicine	3129	Psychiatrist	3205	Veterinary Officer, Remount
		3130	Neuropsychiatrist	3221	Meat and Dairy Products Inspector
3006	Medical Officer, Industrial Medicine	3131	Neurosurgeon	3222	Meat Products Inspector
		3138	Medical Officer, Tropical Medicine	3223	Dairy Products Inspector
3007	Malariaologist (MC)			3231	Veterinary Officer, Laboratory
3012	Hospital Administrator	3139	Internist	3303	Medical Officer, Laboratory
3020	Vital Statistics Officer	3150	General Surgeon		
3100	Medical Officer, General	3151	Thoracic Surgeon		
3101	Medical Officer, Tuberculosis	3152	Plastic Surgeon		
3104	Proctologist	3153	Orthopedic Surgeon		
3105	Gastro-Enterologist	3170	Dental Officer		

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3306 Radiologist	3420 Hospital Dietitian	4012 Director of Supply
3307 Bacteriologist (MSC)	3430 Nurse, Administrative	4110 Mess Officer
3309 Biochemist (MSC)	3437 Nurse, Neuropsychiatric	4490 Medical Supply Officer
3310 Parasitologist (MSC)	3443 Nurse, Operating Room	4890 Medical Equipment
3311 Serologist (MSC)	3445 Nurse, Anesthetist	Maintenance Officer
3314 Clinical Laboratory Officer (MSC)	3449 Nurse, General Duty	4891 Optician
3315 Entomologist (MSC)	3500 Medical Officer, Command	5004 Information-Education Officer
3316 Nutrition Officer (MSC)	3503 Ambulance Officer	5310 Chaplain
3318 Pharmacist	3504 Litter Officer	5521 Physical Training Officer
3325 Tissue Pathologist	3506 Medical Assistant (MSC)	7316 Toxicologist
3327 Aviation Physiologist	3605 Psychiatric Social Worker (MSC)	7960 Sanitary Engineer
3418 Physical Therapy Aide	4000 Supply Officer, General	8547 Medical Photographer

Category I - Expires 1 year from date of current birthday.
 Category II - Expires 2 years from date of current birthday.
 Category III - Expires 3 years from date of current birthday.
 Category V - Desires relief from AD at earliest opportunity. Med Off requires

24 months service, less travel time to ZI and terminal leave.

Category VI - 12 months.) Categories VI, VII & VIII are no longer authorized. Personnel
 Category VII - 18 months.) having signed these categories and not desiring to upgrade
 Category VIII - 24 months.) them are required to serve them out.

XI. Recent Department of the Army and FEC Publications

AR 150-5, C 4, DA, 10 Sep 48, par. 17, "Enlisted Reserve"

AR 615-367, DA, 13 Sep 48, "Enlisted Personnel - Discharge"; par 7, Effect of Disability upon Resignation"

AR 600-395, DA, 22 Sep 48, "Personnel - Prisoners at U.S. Disciplinary Barracks", Sec III par 25 d

AR 40-15, DA, 27 Sep 48, "Dental Corps - General Provisions", supercedes AR 40-15, 23 Aug 46, including C 1, 25 Apr 47

AR 605-12, DA, 30 Sep 48, "Temporary Promotions in the Army of U. S."

AR 35-2025, C 1, DA, 4 Oct 48, "Pay and Allowances Army Nurse Corps and Women's Medical Specialist Corps of Regular Army"

G.O. 63, DA, 20 Sep 48, "Units Entitled to Battle Credits"

G.O. 66, DA, 24 Sep 48, Sec II - "Retiring Boards"

SB 8-36, DA, 2 Sep 48, "Quarterly Dropping Allowance for Minor Items of Non-Expendable Organizational Equipment"

CIR 279, DA, 14 Sep 48, "Disposition of Exposed X-Ray Films", Rescinds par 1 b, DA Cir 35, 48

CIR 283, DA, 16 Sep 48, Sec II, "Physical Examinations, Waivers, Disqualifications, Injury and Disease" - on short tours of active duty training for members of organized Reserve Corps

CIR 288, DA, 22 Sep 48, Sec III, "Officer", Procedure established for removal of officers from active list Regular Army"

CIR 296, DA, 27 Sep 48, "Retiring Boards Terminated at Certain General Hospitals"

CIR 299, DA, 28 Sep 48, Sec I, "AR 40-210", par 23 b(3) changed

CIR 301, DA, 29 Sep 48, "Restoration of General Prisoners", par 2 b

CIR 302, DA, 30 Sep 48, Sec VII, Rescission: "SB 8-35, 15 Aug 46, Pertaining to Drugs and Biologicals, Rescinded and Changed"

CIR 304, DA, 1 Oct 48, "AR 605-250 - Concerning Air Force Retiring Boards, as well as Appointment of Two Medical Officers to make Physical Exam of Officer Ordered Before Board"

CIR 305, DA, 1 Oct 48, Sec VI, TM 38-505, 20 Jun 47, par 32 e, rescinded, and substitution made

on drugs and biologicals

CIR 306, DA, 5 Oct 48, "Appointment in ORC of Warrant Officers and EM Personnel of AUS"

CIR 309, DA, 5 Oct 48, Sec II, "Conscientious Objectors"

CIR 314, DA, 8 Oct 48, "Influenza Vaccinations"

CIR 315, DA, 8 Oct 48, "Implementation of Career Guidance Plan for Warrant Officers and EM Personnel"

CIR 318, DA, 12 Oct 48, "Enlistment of Women in Women's Army Corps, Regular Army and in the United States Air Force" pertaining to physical requirements

MEMO 40-1005-8, DA, 14 Sep 48 and C 1, "Exposed X-Ray Film (File Questionnaire)"

MEMO 145-10-46, DA, 14 Sep 48, "Programs of Instruction for Dental, Pharmacy and Veterinary Senior ROTC Units"

MEMO 700-10-22, DA, 30 Sep 48, "Oversea Supply Division"

T/O&E 12-42, C 2, 3 Sep 48, "Headquarters and Headquarters Company Replacement Depot"

T/O&E 6-160N, 22 Sep 48, "Division Artillery, Armored Division", Sec III

T/O&E 5-250-1, 29 Sep 48, "Headquarters and Headquarters Company, Engineer Brigade", Sec III

T/O&E 44-25, 4 Oct 48, "Antiaircraft Artillery Automatic Weapons Battalion, Mobile", Sec III

T/O&E 44-15, 5 Oct 48, "Antiaircraft Artillery Gun Battalion (90 mm)", Sec III

GHQ, FEC, CIR 39, 9 Oct 48, "Insect and Rodent Control"

GHQ, SCAP, CIR 28, 11 Oct 48, "Shipment of Pets" stating veterinary services, including boarding facilities cannot be furnished by occupation forces, etc," Sec II, par 6 g (2)(a)

GHQ, FEC, CIR 41, 12 Oct 48, "Payment for Blood Donations"

GHQ, FEC, CIR 43, 16 Oct 48, "Refrigeration and Air Conditioning", pars 3 b and 5 d

PART II

TECHNICAL

SUBJECT

SECTION

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XII. General Surgical Seminar Conducted at the 49th Medical General Hospital, Tokyo, Japan. Comments were made by Dr. Edward Speir, M.D., Civilian General Surgical Consultant

Case #1: "Hernia Repair"



Case presented is that of a 7 months old baby, who had a right hernia repair because of inability to keep the hernia reduced when the child was crying and apparent pain when the sac was filled.

Question:

Dr. Speir, what we would like to know is at what age you would repair and at what interval?

Answer:

Don't do elective surgical inguinal hernias under 2 years because of the possibility of getting wound infections. Over and above that, the child is so tiny that with bilateral defects it is just possible that bilateral atrophic testicles may result which is a catastrophe. If the child is a little older, that incident is less likely to happen. When a person is 60 years of age, or over, he is no longer a candidate for elective surgery. It may be 55 for one and 65 for another, but it is well to have some figure in mind. The patient is physically not a candidate for surgery. If it is an emergency, then that is a different story, but take time to evaluate the risk and if it is not worth it, don't do it. My mother, 80 years old, has cholecystitis. She has had attacks since 65 years of age. She has often been in the hospital for maybe two days or almost a week with an acute flare up. Her doctor called me on the phone last summer and said she should be operated upon, and I refused to give my consent. She can spend between 2 or 3 days a year in a hospital and be treated without operation. If she were jaundiced, that would be a different thing. That is not elective surgery. If she had a perforated gall bladder that would be a different story, or if she had gall bladder stones on X-ray film. Under 2 years of age, operative procedures should almost always be for emergency, or if patient is incapacitated by a large hernia. I understand this infant had a bilateral hernia. I would do it in stages. I rarely do bilateral hernias. Wound infections from unilateral herniorrhaphy is 4% in good hospitals; bilateral hernia - 12%. Do one side and then say, 5 or 6 days later when that wound is getting along perfectly well, do the other.

Question:

What about the appendix?

Answer:

I don't deny it can be done and I know that some surgeons on occasion do a right inguinal hernia and then reach up and do an appendectomy. You do surgery for therapy, not to take out multiple organs. We get to thinking that everybody is sick. The average American does not go in the hospital during his lifetime. You have to remember that. If you don't your thinking definitely becomes warped. If the patient has appendicitis, then one should do an appendectomy. If the patient has hernia, then one should repair the hernia. I personally can't do as good a job doing multiple procedures. There is a risk in every surgical procedure; many are quite small, but if it is you that is 100% for you; also 100% for your wife. In doing an operative procedure make an incision so that you can work carefully and be meticulous. Get that patient well of that disease. Don't treat 10 patients just treat one. You can't treat the other 150 or 650 in the hospital and operate at the same time. You can do only one thing and do it well. By adequate exposure or incisions, I say the important thing is to do what you are doing well. If you have adequate exposure, then most of the surgical procedures are very simple. They were doing that 1500 years ago and are still doing the same thing, only we have a different concept about technique today.

Case #2: "Gastric Ulcer"

- (1) Case presentation of a 46 year old white male with a chronic gastric ulcer.
- (2) Case presentation of a 49 year old white female with a two year history of intermittent epigastric pain and a 4 month history of intermittent vomiting. X-rays revealed a persistent radiographic finding near the pylorus which suggested hypertrophic pyloric stenosis, although carcinoma could not be ruled out. This patient was explored and a sub-total gastrectomy and retro-colic gastro-enterostomy were done. Pathological examination revealed a chronic, pre-pyloric, gastric ulcer with no evidence of malignancy.

Question:

In this case had not the ulcer been present, what type of surgery would you do? Do you advocate exploration for any gastric ulcer that does not heal?

Answer:

We know that children have pyloric stenosis but I have never seen anything like this before in an adult. Is the pathologist quite certain she does not have malignancy? She apparently had a long partial obstruction. Some may retain 1700 cc of fluid. Such patients should be coaxed along because these tissues are very poor. With a large dilated stomach, carry the patient

along with supportive measure of all types for a matter of 5-7 days. The patient's state of nutrition is the important thing. We know that distension in small or large bowel is not conductive to surgical maneuvers. Any information at your finger tips may be helpful in knowing what kind of procedure you want to do. Some men feel that the acid determination is of no value. However, this may be very helpful in determining the type of procedure you will do. I do the ordinary Hoffmeister-pfinnster type with a retrocolic short loop gastroenterostomy. If you do a short loop, your operative procedure is more physiological. The ulcers on the greater curvature are almost always malignant. If you take out something you should know why you are doing it. The evaluation of peptic ulcers requires a careful workup. The patient should be treated medically for a reasonable length of time.

Question:

Do you prefer the open or closed technique for anastomosis?

Answer:

In doing any anastomosis on most, do one of three methods. Either he does 1) open anastomosis, 2) closed anastomosis, 3) or semi-closed. Again any anastomosis must be either end to end, end to side, or side to side. The open anastomosis in the absence of obstruction is considered the best. One can control hemostasis and place sutures more accurately with this method. When these things are observed, water tightness and adequate blood supply, one has a good anastomosis.

Case #3: "Appendicitis"

Case presented is that of a 19 year old soldier with intestinal obstruction following an appendectomy.

Question:

What are your views on burying or inversion of the stump in doing an appendectomy?

Answer:

I have on occasion not buried the stump. It is a matter of preference. Basically you are trying to correct pathology. The primary job is to restore the patient to health. The method which does this best in any particular case is the one to use. As to incisions, the McBurney incision as a general rule is quite satisfactory, providing the male is not fat. In females, with the possibility of ovarian disease, I use a transverse, paramedian or a right rectus muscle-splitting incision. These give adequate exposure.

XIII. Fatigue Fractures - presented by Major D. A. Richmond, MC



The first fractures of this nature were described in the metatarsals as March Fractures or Deutschlander's Disease and it was a common enough lesion in recruits in the 1914-18 War but the occurrence of this type of fracture in other bones was not recognized apparently, until comparatively late. Blair Hartley pointed this out and adds their evidence in America and Great Britain appears to be low, few workers having described more than 2 cases. On the other hand Sheller in 1939 reported 590 examples from German field hospitals arising in the years 1935 and 1936. More than 100 of these occurred in bones other than the metatarsals. Roberts and Vogt in 1939 published 12 cases of "pseudo-fracture" of the tibia which were fatigue fractures. As might have been suspected many cases have been reported from the English speaking nations during this last war and almost every bone which is subjected to persistent stress has been found

to develop fatigue fractures.

PATHOLOGICALLY: The lesion is thought to be akin to the fractures which occur in stressed metals - for instance the various parts of a steel bridge. It is a defect which occurs in the crystalline structure of the metal and though I can find nothing in the literature at my disposal concerning the microscopical evidence of the same defect in the osseous structure. I recall a lecture by a Swiss professor when I was a medical student, I forget his name, on the crystalline structure of bone - he termed these defects "bone exhaustion".

A word should be introduced at this juncture concerning nomenclature. I have entitled my talk "Fatigue Fractures," purposely omitting the words March and Stress from the title. During the war, I collected 40 odd cases of these lesions and published short articles on the more interesting ones. In the course of correspondence with Blair Hartley, who is one of the acknowledged radiological experts on the disease he pointed out to me the undesirability of using the term stress or march applied to these fractures. That they are fractures is shown by the fact that in one of Hartley's cases actual displacement occurred. Stress is an unsuitable term because obviously any fracture is due to some sort of stress and I advocate dropping this title as being too wide in its sense. On the other hand March is much too narrow in its meaning because this type of fracture has been described in housewives, skaters, school children, etc, etc. Hence I think a strong case has been made out for the use of the term FATIGUE which implies the development of a bony defect due to oft repeated strains each in itself very far from sufficient to produce the fracture. "Fatigue" is the term I believe, used by the metallurgists to describe the similar condition in metals.

SIGNS AND SYMPTOMS: The usual history is that the patient complains of pain at the site of the fracture. He will usually admit to some strenuous exercise sometimes of an unaccustomed nature indulged in over the preceding few weeks.

The pain is made worse by exercise and improved by rest. It is described as a dull ache and is never severe in those cases I have seen.

Clinically: If the site of the fracture is subcutaneous there will be oedema of the overlying skin. At the site will be found "point tenderness". It may be possible to produce pain at the fracture site by applying stress to the bone. For instance in my two cases of fatigue fracture at the lower end of the fibula eversion of the heel caused pain at the site of tenderness. This movement would tend to widen the ankle mortice and so bend the fibula against the tension of the inferior tibio-fibular ligament acting as a fulcrum.

RADIOLOGICALLY: In the early stages, i.e. during first 2 or 3 weeks, after the onset of symptoms there may be no visible abnormality. The first radiological evidence is usually a faint cloud of callus seen at a point corresponding to the site of tenderness. This callus often overlies a cortical nick or notch and appears on the stressed aspect of the bone. Extending across the bone from this cortical defect may be seen a hair-like fracture line. If this is not seen, and often it may not be visible, a late film will show a "condensation" of endosteal bone extending across from cortex to cortex. Serial films show a gradual increase in extent of the callus which may extend up, down and around the bone though it remains thickest on the stressed surface of the bone. This callus gradually consolidates and becomes denser and eventually it may come to form a buttress across the concavity of the bone which is the stressed aspect of the bone surface.

The pain and tenderness persists for many weeks and gradually becomes less and less until perhaps a little tenderness, but no pain, is the only symptom. This tenderness slowly disappears. Some bony thickening, usually remains.

More than one fatigue fracture may occur in the same person and in the same limbs. For instance, multiple metatarsal fractures have been described and I have had a patient with a metatarsal and a fibular lesion in the same limb.

The bone affected is normal elsewhere along its length and no systemic defects can be found in the patient.

Blair Hartley demands the following criteria for the diagnosis of fatigue fractures:

1. Pain after exercise over one of the long or stressed bones.
2. Callus appearing at the site of the pain which gradually increases in amount and steadily consolidates.
3. An easily missed fracture line, often no more than a hair line fissure.
4. Radiological findings localized to the concave or stressed aspect of the bone.

The Differential Diagnosis: must be made with care although it is usually easy. It is important to make the diagnosis because it has been shown in the case described by Hartley that if untreated the fracture can become displaced and presumably be complicated in the same way as any other fracture with displacement.

Obviously the painful bone which is tender and the skin over which is oedematous might lead to a diagnosis of periostitis or even osteomyelitis. These can be excluded by the absence of con-

stitutional symptoms fever toxaemia etc. The periostitis radiologically might appear similar to the callous formed around the fatigue fracture but the callous tends to be more localized and more heaped up. A Wasserman and Kahn reaction would exclude syphilitic periostitis.

The extension of the callus around and along the lengths of the affected bone may simulate the onion skin layering of Ewing's tumor or the heaping up of the callus may call to mind an osteogenic sarcoma. These two malignant tumors must be borne in mind but in fatigue fractures there is never a soft tissue tumor. However, any doubt must be resolved by resort to a biopsy. This I have done in one case - a demoral shaft lesion.

Another tumor to be considered is osteoid osteoma. Here there is pain and tenderness localized in a bone, not necessarily a stressed bone and radiologically there is a reactive bony process in the cortex but this reaction is a sclerosis and is much greater in extent than the thin layering of callus around the cortical defect of a fatigue fracture. Usually within the reactive sclerosis is seen a relatively translucent area, ovoid in shape, which is the osteoid osteoma. This condition of osteoid osteoma is probably the same disease as chronic sclerosing osteomyelitis in which, unless various films are exposed to X-rays of varying penetrative power the oval area will probably not be seen. These two diseases if they are not one and the same (and they probably are) resemble a fatigue fracture only in their very early stages when there is not much reaction. It was Jaffe in 1940 who pointed out that these cases of sclerosing non-suppurative osteomyelitis were in reality thought to be cases of osteoid osteoma (a condition he had first described 5 years before). Whether these lesions are bone neoplasms or infective foci we need not go into here, but they should be borne in mind when discussing the diagnosis of fatigue fractures.

The more deeply situated fatigue fractures such as those occurring in the femur may call attention to the neighboring joint and the lesion in shaft or neck itself may be missed. This happened in one case with a fatigue fracture in the lower third of the femur. The lesion caused pain which the patient referred to the knee joint. Radiologically and clinically nothing abnormal was found in the joint and later when reviewing the case the callus was noticed just visible at the upper edge of the knee joint film and it was palpable through the vastus medialis. So keep this type of fracture in mind when dealing with unexplained joint pains.

Obviously contusion and sprains should be thought of when considering the differential diagnosis.

SITE: At this point might be mentioned the various sites at which the fatigue fractures have occurred. I shall indicate any special differential necessary.

The commonest is the metatarsal neck and shaft, usually the 2nd metatarsal, often the 3rd or 4th, but they have been described in all the metatarsals. Here Freiburg's infraction must be considered in the clinical diagnosis though radiologically there is not much similarity. In Freiburg's disease the radiological changes are mainly limited to the metatarsal head which collapses and the articular surface fragments. There is a compensatory thickening of the neck but no cortical notch or callus is ever seen. The fatigue fracture affects usually the shaft. The site of entry of the nutrient artery into the shaft of a metatarsal must be distinguished from the cortical defect I have mentioned. Whilst discussing fatigue fractures in the metatarsals I might perhaps point out that, despite what most of the published articles say about the aetiology of these metatarsal lesions - I mean the so-called increased strain thrown on the 2nd metatarsal particularly, because the first is the shorter bone, this argument is fallacious. No less authority than Professor Watson-Jones has pointed out that the normal is a shorter 1st metatarsal. It is abnormal for the 2nd metatarsal to be shorter than the 1st. The next commonest site is the upper third of the tibial shaft where the cortical nick is seen on the medial concave surface surrounded by its callos and from it extending across the bone, either the hair line fissure or the condensation of endosteal bone.

The tibia is also affected sometimes in its lower 1/3.

The fibula may develop fatigue fractures in its lower or its upper third. Ingersoll has said that the fracture in the lower third 2" above the tip of the malleolus is found at the point of maximum stress. It is the point where bending takes place when the foot is laterally rotated or everted, the talus forcing the fibula laterally so that, with the inferior tibio fibular ligament acting as a fulcrum the fibula bends at its narrowest point. These cases occurred in novice ice skaters. The femur develops the lesion in its lower third and across its neck.

The calcaneus is another bone affected.

A colleague of mine has shown me a film of a radial fracture demonstrating all the signs of a fatigue fracture, it occurred in a labourer who had been digging heavy soil. Presumably the continued pronation and supination when lifting a heavy weight had caused the lesion. A lesion re-

sembling fatigue fracture has been described in the first case.

TREATMENT: Consists essentially of Rest and Removal of Strain from the affected bone. Considering each bone in turn -- the femur -- here the patient should be preferably kept in bed for about 4 weeks and then allowed up on crutches and as the lesion shows evidence on X-ray of healing gradual resumption of weight bearing should be allowed. The tibia should be treated similarly where the lower third of the fibula is concerned, because the only harmful strain is the eversion one. I suggest a short leg plaster with weight bearing as the treatment of choice. The plaster being retained for 3 weeks. The plaster fixation is not essential, crutches or bed rest should suffice.

I do not think plaster fixation is necessary for the metatarsal or tarsal lesions - merely prohibit weight bearing for 2 - 4 weeks until the acute phase has passed off and then allow gradual resumption of normal activity.

XIV. Diagnostic and Therapeutic Novocaine Injections in Orthopedic Practice - presented by Colonel E. W. Hakala, MC (In two parts - Part I)



INTRODUCTION:

HISTORY: Acupuncture, the therapeutic insertion of needles, has been in use since 300 A.D. Huang Fu described the treatment of painful lesions by insertion of long needles into the subcutaneous and muscular tissues. Since then it has been popular to inject soft tissues with various anesthetic or sclerosing agents, alone or in combination, as diagnostic and/or therapeutic adjuncts. Leriche and Steindler are the principal modern advocates of this work.

PURPOSE: Today I intend to discuss the more common uses of novocaine injections from a diagnostic as well as therapeutic standpoint. Most of this work is done on an out-patient status. If time permits, it should be professionally satisfying to those doctors on dispensary assignments.

GENERAL TECHNIC ROUTINE: Give 1-1/2 grains of nembutal 20--30 minutes before injection. Procaine reactions are not uncommon, but are usually harmless. Have patient lie down for 20--30 minutes following the injection because of the possibility of dizziness, nausea, or faintness. If severe reaction occurs, change to metycaine for subsequent injections and use as little as possible.

Use 2% novocaine when you need only a small amount of drug. If more than 15 cc is used, use 1%. Ordinarily do not use more than 60 cc.

Sterile technic is mandatory. This usually means that the skin is shaved, washed with soap and water, followed by merthiolate.

Equipment: Sterile towels, rubber gloves, syringes, medicine glasses, needles of various sizes; 25 gage for skin wheal, 22 or 23 gage for injection, the length depending upon the depth of injection -- we usually use spinal needles.

Injection is made into areas of maximum tenderness which are located by finger-tip palpation until no tender or painful areas remain on palpation or motion of the involved joint or area.

Draw back on syringe before each injection to avoid injection directly into a blood vessel.

Inject as wide an area through each skin wheal as possible to minimize the number of skin punctures necessary.

Warn the patient that usually after the anesthesia wears off that her symptoms will be aggravated for about 12--24 hours, but that then she should be better than before the injection.

RATIONALE: This will be mentioned for each of the conditions discussed.

SPRAINS:

DEFINITION: A sprain is a stretching or tearing of ligaments or the capsule about the joint. They are classified as mild, moderate, and severe; the latter are complete tears and the

two former degrees are partial tears.

PATHOLOGY: In mild to moderate sprains there is partial tear of ligaments and small blood vessels with the formation of a hematoma; the latter is composed of more tissue fluid than actual blood. Most of the pain and loss of function which result are probably due to the tension which develops from the confining of this fluid to a small space. The fluid accumulation and the disuse resulting from pain on motion lead to stiffness of the part. Leriche believed that the circulatory changes following soft tissue trauma are due to sensory nerve ending stimulation by edema and torn tissue. These afferent impulses produce reflex vasodilation. This then produces further effusion which in turn produces more intense sensory impulses. This constitutes a vicious circle which can be broken only by a local anesthetic.

JOINTS: Procaine injection can be used in sprains of any joints, but it is used primarily in sprains of the ankle. Sprains of the wrist and elbow joints are rare; they usually turn out to be dislocations or fractures.

NOVOCAINE INJECTION OF ANKLE SPRAINS:

RATIONALE: The effect from injection of a local anesthetic solution into this tender area persists long enough to permit removal of some of this fluid, sufficient in amount to relieve the tension in the injured area. The relief of pain permits sufficient muscular exercise to cause an increase in local circulation and to exert enough mechanical pressure to force the accumulated fluid into channels for its removal. The gentle massage produced by motion promotes drainage and decreases the effusion.

CONTRAINDICATIONS: Novocaine injection followed by ambulation should never be used in complete tears of ankle ligaments. There are three sets of ankle ligaments which, if completely torn and treated without immobilization and with weight-bearing will inevitably result in laxity of the joint and pain on walking. Before embarking upon ambulatory treatment of an ankle sprain, the doctor must determine whether a complete tear exists. Proper examination may be so painful that one may have to inject the ankle in order to decide.

INFERIOR TIBIO-FIBULAR LIGAMENT: This ligament maintains the ankle mortise. A tear of it can be demonstrated clinically by grasping the ankle just about the joint in one hand and the calcaneus in the other. By moving the calcaneus transversely one can click the astragalus against the malleoli if even a partial tear exists. Any degree of tear of this ligament must be treated with immobilization and non-weight-bearing.

MEDICAL OR LATERAL MALLEOLAR LIGAMENTS: These ligaments prevent inversion or eversion of the astragalus in the ankle mortise. Complete tear of the medial talo-tibial portions of the deltoid ligament will show up clinically as a definite click of the talus in the mortise on forced eversion of the calcaneus. Similarly complete tear of the lateral talo-fibular ligaments will cause a click on forced inversion of the calcaneus. This occurs because the remaining intact talo-calcaneal ligaments will rock the talus in the mortise; this is impossible in the normal ankle except occasionally in women with normally lax malleolar ligaments. In questionable cases, AP x-ray views should be taken with the calcaneus held in forced inversion or eversion depending upon the ligaments being tested. If the talus is tilted in the mortise, the diagnosis is made.

(Part II of this Article to be concluded in next month's (January 1949) issue of the Surgeon's Circular Letter)

XV. Production Data on Dental Officers



With the number of dental officers on duty in the Far East Command, about to reach its lowest level, the amount of dental work produced at the present personnel level has been a matter of considerable interest.

In order to obtain figures for comparison, consolidated dental reports for two typical months have been used - April and August 1948. Personnel during both months were fairly stable.

In two respects they vary widely. In April, there were 234 dental officers assigned, predominantly non-volunteer and company grade. In August, the number assigned had dropped to 142, predominantly volunteer, and divided about equally between company and

field grade.

Data gathered from these two months reveal one fact. With 92 fewer dental officers in August than in April, the same amount and in some instances more dental operations were performed in August than in April.

In practically every instance where a comparison has been made, the production rate per officer per day was definitely higher in the August group.

Although the volunteer group is made up of individuals who have had much more experience in the profession than the non-volunteer group, the latter had at least twenty-one months' Army experience under ideal conditions, for the most part, to develop operative technique and speed.

Comparative data sheets for FEC, FEAF, Eighth Army, XXIV Corps, MARBO, and the 332nd Medical General Dispensary are listed below. The dispensary was chosen for this purpose as complete dental service is furnished with the exception of jaw fractures, and cases requiring hospitalization.

Production Comparison Table

	<u>April - 234 Officers</u>			<u>August - 142 Officers</u>		
	<u>Military</u>	<u>Others</u>	<u>Total</u>	<u>Military</u>	<u>Others</u>	<u>Total</u>
Admissions Routine	12,514	1,821	14,335	10,800	1,649	12,449
Admissions Emergency	1,721	643	2,364	2,143	841	2,984
Total Admissions	<u>14,235</u>	<u>2,464</u>	<u>16,699</u>	<u>12,943</u>	<u>2,490</u>	<u>15,423</u>
Sittings Given	39,836	6,991	46,827	35,807	6,322	42,129

Restorations

Amalgam	9,850	1,614	11,464	10,229	1,292	11,521
Gold foil	8		8	2		2
Inlays	156	22	178	70	16	86
Oxyphosphate & amalgam	5,261	709	5,970	5,650	751	6,401
Root Canal	25	5	30	7	5	12
Silicate	2,704	522	3,226	2,886	498	3,384
Oxyphosphate & silicate	386	80	466	439	178	617
Total Fillings	<u>18,390</u>	<u>2,952</u>	<u>21,342</u>	<u>19,283</u>	<u>2,740</u>	<u>22,023</u>

Prothesis, New

Bridges	135	17	152	125	7	132
Crowns	84	28	112	36	6	42
Dentures, full	145	60	205	180	54	234
Dentures, partial	573	112	685	738	56	794
Total	<u>937</u>	<u>217</u>	<u>1,154</u>	<u>1,079</u>	<u>123</u>	<u>1,202</u>

Prosthetic Repairs and Adjustments

Bridge repaired	82	25	107	91	16	107
Crowns repaired	16	5	21	22	13	35
Dentures rebased	30	16	46	22	2	24
Dentures repaired	232	63	295	208	43	251
Bridge recemented	47	17	64	61	16	77
Crown recemented	12	6	18	13	7	20
Denture adjusted	392	114	506	554	133	687
Denture reconstructed		1	1			
Total	<u>811</u>	<u>247</u>	<u>1,058</u>	<u>971</u>	<u>230</u>	<u>1,201</u>

Other Operations

Anesthesia local	5,509	1,517	7,086	4,992	1,541	6,533
Calculus removal	3,616	583	4,199	5,055	633	5,688
Examinations	20,469	2,383	22,852	16,061	2,390	18,451
Gums treated	2,225	430	2,655	3,484	408	3,892

RESTRICTED

	<u>Military</u>	<u>Others</u>	<u>Total</u>	<u>Military</u>	<u>Others</u>	<u>Total</u>
Post-operative treatment	1,675	417	2,092	1,837	412	2,249
Teeth treated	2,719	766	3,485	1,721	634	2,355
X-ray exposure	5,544	1,540	7,084	5,012	1,649	6,661
Teeth extracted	3,763	1,420	5,183	3,767	1,370	5,137
Teeth replaced	5,257	1,395	6,652	6,191	1,070	7,261

PRODUCTION RATE PER DAY PER OFFICER

Far East Command

<u>Month</u>	<u>Officers</u>	<u>Fillings</u>	<u>Dentures</u>	<u>Extractions</u>	<u>Sittings</u>
April	234	3.04	.164	.74	6.67
August	142	5	.271	1.17	9.57

Eighth Army

April	104	2.781	.183	.643	6.641
August	62	4.223	.263	1.081	9.265

XXIV Corps

April	45	2.185	.094	.374	5.048
August	25	4.863	.221	.82	8.736

MARBO

April	10	3.303	.3	.906	10.993
August	8	7.77	.467	1.295	11.665

Far East Air Forces

April	34	4.008	.132	.866	7.485
August	24	5.331	.231	1.091	12.001

332nd Medical General Dispensary

April	18	2.33	.392	.755	6.01
August	11	5.55	.445	1.29	9.30

PART III

STATISTICAL

Evacuation:

1. During the period 28 August to 24 September 1948, the following number of patients were evacuated from the several major commands:

	<u>AIR</u>	<u>WATER</u>	<u>TOTAL</u>
JAPAN	95*	286*	381*
KOREA	242**	0	242**
MARBO	49	1	50
PHILCOM	13	0	13
RYCOM	19	0	19

* Includes air evacuees from Korea

** Patients evacuated to Japan for onward evacuation.

2. Evacuations of military personnel per thousand strength for the period 28 August to

24 September 1948 were as follows:

JAPAN	5.5
KOREA	9.7
MARBO	2.6
PHILCOM	.71
RYCOM	1.2
FEC	4.8

Hospitalization:

1. The bed status as of 24 September 1948 was as follows:

	<u>Total T/O Beds Auth</u>	<u>Total T/O Beds Establ</u>	<u>Total T/O Beds Occupd</u>
JAPAN	4,450	4,425	2,212
KOREA	1,900	1,096	379
MARBO	825	488	319
PHILCOM	1,600	1,520	864
RYCOM	750	450	298
FEC	<u>9,525</u>	<u>7,979</u>	<u>4,072</u>

2. The percent of T/O beds and established beds occupied as of 24 September 1948 was as follows:

	<u>Percent Auth T/O Beds Occupd</u>	<u>Percent of Establ Beds Occupd</u>
JAPAN	50	50
KOREA	20	35
MARBO	39	65
PHILCOM	54	57
RYCOM	40	66
FEC	43	51

3. Admission rates per 1,000 troops per annum for the four (4) week period ending 24 September 1948 were as follows:

	<u>FEC</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILCOM</u>	<u>RYCOM</u>
All Causes	566	682	763	219	426	334
Disease	509	621	686	191	382	288
Injury	56	62	77	29	44	47
Psychiatric	15	13	29	16	10	3.7
Common Respiratory Disease	54	63	75	16	69	6.1
Influenza	1.4	2.0	.81	1.0	1.1	0
Primary Atypical Pneumonia	5.3	4.9	8.1	8.8	0	4.3
Common Diarrhea	11	3.3	43	1.0	10	7.4
Bacillary Dysentery	1.2	.14	3.2	.52	1.6	2.5
Amebic Dysentery	1.1	.43	2.4	.52	2.2	1.2
Malaria	10	1.4	32	.52	8.7	17
Infectious Hepatitis	4.7	4.3	6.9	2.6	4.4	1.2
Mycotic Dermatoses	6.6	7.9	17	0	0	1.2
Rheumatic Fever	.41	.43	0	0	.55	.61
Venereal Disease	112	138	185	18	46	71

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Major General Bethea extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor